TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EUGEN L HEIMAN MD

Respondent Name
GRAPHIC ARTS MUTUAL INSURANCE

MFDR Tracking Number
M4-15-1915-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE ABOVE PATIENT WAS SEEN IN THE OFFICE ON DOS 09/19/2012 FOR A WORK RELATED INJURY. PRIOR TO SCHEDULING THE PATIENT FOR THE FIRST EVALUATION, I SPOKE TO THE ADJUSTER AND VERIFIED THE CLAIMS ADDRESS, DISCUSSED COMPENSABLE INJURIES, AND CONFIRMED THAT WE INDEED HAS REASONABLE AND NECESSARY TO EVALUATE AND XRAY THIS PATIENT. ONCE THE EXAM WAS COMPLETED, THE CLAIM WAS GENERATED AND SUBMITTED ELECTRONICALLY 09/252012. THE CLAIM WAS NEVER PROCESSED. WHEN I RESUBMITTED, THE CLAIM WAS REPEATEDLY DENIED AS A DUPLICATE AND TIMELY FILING. I DID FILE THIS CLAIM TO TIME. THE CLAIM SHOWED ACCEPTED ELECTRONICALLY AND WHEN IT CAME TO MY ATTENTION THAT THE PAYMENT HAD NOT COME, I RESUBMITTED AS A RECONSIDERATION VIA MAIL. EVERYTIME I SENT SOMETHING TO THE ADDRESS THE ADJUSTER PROVIDED, IT CAME BACK AS UNDELIVERABLE."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This will acknowledge the receipt of your notice dated March 3, 2015 for Medical Fee Dispute Resolution filed by the provider listed above regarding charges for date of service September 19, 2012

Utica National respectively requests this request be dismissed as this is a WCHN claim and MFDR is not the proper venue, failed to timely submit their original billing or request for reconsideration, and finally, failed to request MFDR within one year from the date of service in question. The medical bill in question was first received by Utica on July 15, 2013."

Response Submitted by: Utica Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2012	CPT Code 99455	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - 224 – Duplicate charge
   - A82 – Duplicate claim/service/bill

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is September 19, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 24, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		5/8/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.